



Rock Creek Imaging

Patient Information	Insurance
Patient Name _____ SSN _____ Date of Birth _____ Age _____ Sex _____ Marital Status _____ Address _____ City _____ State _____ Zip _____	Who is the Primary Card Holder for this account? _____ Relationship to Patient _____ Primary Insurance _____ ID # _____ Group # _____ Secondary Insurance _____ ID # _____ Group # _____ Is Condition due to an accident? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Accident _____ Type of Accident <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> Other Other _____ To who have you made a report of your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Work Comp <input type="checkbox"/> Other Attorney Name (If Applicable) _____
Patient Employer/School	
Name _____ Phone _____ Address _____ City _____ State _____ Zip _____ Occupation _____	
Other (Primary Card Holder - Guardian/Spouse)	
PCH Name _____ PCH Date of Birth _____ PCH Employer _____ Emergency Contact _____ Referring Physician _____	Contact Home Phone _____ Cell Phone _____ E-Mail _____

General Information Relating to Payment of Account

Please arrange for payment of diagnostic testing and other procedures with the receptionist before leaving, unless a prior agreement has been made. Medicaid will not be accepted unless another physician has referred you. **Even though an insurance claim may be filed, you are responsible for the total amount of your account, and you will receive a statement if your account has a balance due.** This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

The patient, patient's guardian, or guarantor is primarily responsible. It also must be definitely understood this office will not be responsible for any omission or non-payment of the claim for any reason whatsoever. A charge will be made for all forms not related to the payment of the bills of this office. **In the event collecting of this account is required through legal means and/or agency, the undersigned and/or patient hereby agrees to pay any and all costs accrued to collect this account.**

I hereby authorize Rock Creek Imaging to release the medical information contained in my medical record in their files, to family physicians, referring physicians and/or for insurance purposes. I understand that the information I am authorizing you to release is of a confidential nature, and that the insurance carrier may use this information as a reason to increase my rates or deny coverage to me. A photographic copy of this authorization shall be as valid as the original.

I hereby authorize payment directly to Rock Creek Imaging of the medical benefits otherwise payable to me, but not to exceed the Associate's regular charges for these particular medical services. I understand that I am financially responsible to Rock Creek Imaging for charges not covered by this authorization. A photographic copy of this authorization shall be valid as the original.

I authorize Rock Creek Imaging to perform my radiological exam as prescribed by my physician.

Patient/Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our facility is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances maybe be required. The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to restrict our disclosure of your health to only certain individuals involved in your care or the payment for your care, such as family members and friends.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decision about you. You may ask us to amend your health information if you believe it is incorrect or incomplete. You have right to file a complaint. If you believe your privacy rights have been violated.

I hereby acknowledge that I have been presented with a copy of Rock Creek Imaging's Notice of Privacy Practices.

I _____, authorize the release of my medical/billing information or my actual films to:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

- I refuse to release my information to any other person besides my physician and myself. I realize that forgoing the above allows for no one but me to pick up my films, billing information, or medical records.

Printed Name of Patient/Guardian

Signature of Patient/Guardian

Date